



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMMUNITY FOOD AND NUTRITION ASSISTANCE
CHILD AND ADULT CARE FOOD PROGRAM

FAX # 573-526-3679
PO BOX 570
JEFFERSON CITY MO 65102-0570

CLAIM FOR REIMBURSEMENT

READ INSTRUCTIONS ON REVERSE SIDE CAREFULLY BEFORE COMPLETING CLAIM.

1. NAME AND ADDRESS OF INSTITUTION. (PLACE PREPRINTED LABEL HERE.)	2. CLAIM MONTH/YEAR /	3. ORIGINAL <input type="checkbox"/>	4. REVISION <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 1 ST 2 ND 3 RD (CHECK ONLY IF PAYMENT FOR THE ORIGINAL CLAIM HAS BEEN RECEIVED.)
	(MONTH) (YEAR)		
5. PERIOD COVERED BY CLAIM (REQUIRED ONLY WHEN OPERATIONS ARE BEGINNING OR ENDING AND CLAIM INCLUDES 10 OPERATING DAYS OR LESS IN THE PRIOR MONTH AND/OR 10 OPERATING DAYS OR LESS IN THE FOLLOWING MONTH.) START DATE END DATE		6. TOTAL NUMBER OF DAYS IN CLAIM PERIOD DURING WHICH MEALS WERE PROVIDED	
7. TOTAL ATTENDANCE FOR MONTH (ENTER THE SUM OF DAILY ATTENDANCE TOTALS FOR EACH DAY MEALS WERE PROVIDED)		8. NUMBER OF CENTERS THIS CLAIM PERIOD FOR WHICH YOU ARE CLAIMING MEALS (INDEPENDENT CENTERS WILL ENTER A "1".)	

TOTAL NUMBER OF MEALS SERVED TO PARTICIPANTS IN DAY CARE CENTERS.

	A. BREAKFASTS	B. LUNCHES	C. SUPPERS	D. SNACKS	13. ENROLLMENT
9. FREE					(FREE)
10. REDUCED					(REDUCED)
11. PAID					(PAID)
12. TOTAL					

COMPLETE ONLY IF YOU HAVE APPROVED AT-RISK SITES.

14. AT-RISK:	A. ATTENDANCE	B. OUTLETS (SITES)	C. SUPPERS	D. SNACKS
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COMPLETE ONLY IF YOU ARE FOR-PROFIT.

15. ELIGIBLE NUMBER IN FOR-PROFIT CENTER(S): NAME OF CENTER(S)	TOTAL ENROLLMENT OR LICENSED CAPACITY FOR CLAIM PERIOD (whichever is less)	ELIGIBLE TITLE XX OR TITLE XIX PARTICIPANTS OR FREE- AND REDUCED-CATEGORY ELIGIBLES
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16. REMARKS

All claims for reimbursement shall be submitted to the Missouri Department of Health and Senior Services no later than the legislatively mandated deadline of 60 calendar days after the end of the claim month. Failure to submit claims within the 60-day deadline may result in such claims not being paid.

I CERTIFY that to the best of my knowledge and belief, this claim is true and correct in all respects, that records are available to support this claim, that it is in accordance with the terms of existing Contract(s); I recognize that I will be fully responsible for any excess amounts which may result from erroneous or neglectful reporting herein. I further certify that claims submitted for meals served in for-profit Title XX or Title XIX centers are submitted for those centers in which 25% or more of either enrollment or licensed capacity were receiving Title XX or Title XIX benefits for this claim period OR in which 25% or more of either enrollment or licensed capacity were free-category and reduced-category eligible for this claim period.

17. SIGNATURE OF AUTHORIZED REPRESENTATIVE ▶	18. TITLE	19. PREPARATION DATE
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THIS SPACE IS FOR MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES CACFP ONLY.

DEPARTMENT CACFP AUTHORIZED SIGNATURE ▶	DATE
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All records supporting the claim for reimbursement must be retained and available for future audit for a period of 3 years and the current year. No further monies or other benefits may be paid out under the Program unless this report is completed and filed as required by existing regulations (7 CFR 226).

Check original claim if claim is first for the billing period and has not yet been accepted for payment. If claim must be revised later for same billing, check "Revision" block.

INSTRUCTIONS

SPECIAL NOTE: A REVISED CLAIM completely voids all previous claims for the same month. Therefore, include ALL reporting data for the entire month's operation. Also, be certain to maintain all pertinent records and adequate documentation to support the claim for reimbursement.

GENERAL

Report data for **one calendar month only**. If the first or last month of operation contains 10 working days or less, such a month may be added to the claim for the appropriate adjacent month. However, DO NOT combine on any claim June meal service information with July meal service information or September meal service information with October meal service information. Your amount of payment will be computed by Community Food and Nutrition Assistance (CFNA) based on the United States Department of Agriculture (USDA) meal reimbursement rates.

This claim will be returned and payment cannot be made if claim is not properly completed. Therefore, sign and date this claim before mailing it to CFNA. If you have any questions about how to complete this form, please contact CFNA for assistance.

Submit the claim to CFNA. All claims must be received in our office by the 10th of the month following the claim month for the first processing cycle or the by the 25th of the month following the claim month for the second processing cycle. All claims must be received or postmarked no later than 60 calendar days following the end of the claim month. The institution must make a copy of the claim before submitting. Keep the copy for your files.

All claims for centers must include entries for items 1-13 and 17-19. Items 5, 14, 15, and 16 must be completed if appropriate.

Send or fax claims to:

**Missouri Department of Health and Senior Services
Community Food and Nutrition Assistance
P.O. Box 570
Jefferson City, MO 65102
Fax # 573-526-3679**

REVIEW YOUR ENTRIES. WHEN YOU ARE SATISFIED THEY ARE TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE, SIGN THE REPORT, AND ENTER YOUR TITLE AND DATE REPORT WAS PREPARED.

Are you interested in submitting CACFP claims via the Internet (online)? Please contact our office at 1-800-733-6251 for further information.

SPECIFIC INSTRUCTIONS

ITEM

1. Check to be sure the pre-printed information is correct. If the contract number or center name and address are missing, please fill in the proper information. If either or both are incorrect, immediately contact CFNA to make corrections.
2. Enter the month and year that this claim covers. For example, January 2005 would be entered as:

01 05
- 3 & 4. Enter if original or revised claim.
5. Complete only if operations are beginning or ending and claim includes 10 operating days or less in prior month or 10 operating days or less in following month. Please note that a claim **cannot** combine June/July or September/October program information.
6. Enter the actual number of days you served meals to participants as part of the Child and Adult Care Food Program.
7. Compute total attendance by adding daily center attendance (not meal counts) for each day of the claim period.
8. Enter the number of centers in operation for this claim period.
- 9-11. Enter the total number of meals by income category (free, reduced, paid) actually served to participants enrolled in all centers.
12. Enter the sum of each meal type.
13. Enter the number of participants enrolled in centers for this claim period by income group.

Free – Enter the number of participants enrolled for which center maintains documentation showing participants eligible in the free category.

Reduced – Enter the number of participants enrolled for which center maintains documentation showing participants eligible in the reduced category.

Paid – Enter the number of participants enrolled for which center maintains no documentation showing participants eligible in the free or reduced category.
14. Complete only if your center is participating/approved in the At-Risk After-School Program.
15. Complete only if your center is for profit. List names of all for-profit centers, total enrollment or licensed capacity for claim period for each center (whichever is less), and the number of eligible Title XX or Title XIX participants or free-category plus reduced-category eligibles in each center.
16. Enter any remarks that you may wish to make.
17. Must be completed with original signature for payment to be disbursed. Original signature must match signature on application. Preparation date cannot occur before end of claim month during normal operations.